Patient Intake Forms

Patient Name:_____ **Date of Birth:**_____/_____/_____

Preferred Name/Pronoun(s): _____ **Sex:** ☐ Male ☐ Female

Height: _____ **Weight:** _____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____

City, State + Zip: _____

Cell Phone: (_____) _____-_____ **Work Phone:** (_____) _____-_____

Email Address: _____ **Home Phone:** (_____) _____-_____

Preferred Reminder Method: ☐ Text ☐ Call ☐ Email

Occupation: _____

Employer: _____

Emergency Contact: _____

Relation: _____

Phone: (_____) _____-_____

Preferred Language: ☐ English ☐ Other: _____

Have you had Physical Therapy this year for any condition? ☐ Yes ☐ No

If yes, for what condition(s):_____

How did you hear about Gnome Physical Therapy?

☐ Doctor ☐ Friend ☐ Social Media ☐ Other: _____

PHYSICIAN INFORMATION

Referring Physician:_____

Office/Clinic:_____

City/Location:_____

Primary Care Physician:_____

Office/Clinic:_____

City/Location:_____

PRIVACY PRACTICES

I acknowledge that I have received or have had the opportunity to receive a copy of the official Notice of Privacy Practices from Gnome Physical Therapy. For coordination of care, I understand Gnome Physical Therapy will share evaluations, progress notes, and other relevant details regarding my care with my referring provider, primary care provider, and/or insurance carrier if applicable.

Signature: _____ **Date:** _____

PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE
Relation to Patient: ☐ Parent ☐ Legal Guardian/Representative

CONSENT FOR COMMUNICATION

INITIAL: _____ I authorize Gnome Physical Therapy to leave detailed messages on my voicemail.

INITIAL: _____ To receive appointment reminders via my preferred method.

INITIAL: _____ To receive communication via text (standard messaging rates apply) from Gnome Physical Therapy.

INITIAL: _____ To receive communication via email from Gnome Physical Therapy.

INITIAL: _____ I authorize Gnome Physical Therapy to discuss my appointments or care with my spouse.

INITIAL: _____ I understand that this does not authorize release of medical information by Gnome Physical Therapy to any other organization or agency unless I grant further authorization. I also understand that these authorizations can be revoked at any time.

CONSENT FOR TREATMENT

I, the Undersigned or legal guardian thereof, do hereby agree and give my consent for Gnome Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating and/or treating my physical condition.

I authorize Gnome Physical Therapy to provide information concerning my treatment and insurance claims forms to my insurance carrier(s) on my behalf, and I authorize for payment of insurance benefits to be made directly to Gnome Physical Therapy for services rendered. In the event my insurance company forwards payment directly to me, instead of to Gnome Physical Therapy, I agree to promptly deliver said payment to Gnome Physical Therapy.

I understand that I am responsible for the total cost of care. If I do not provide insurance information or inaccurate information, I understand Gnome Physical Therapy will bill me directly for incurred charges as well as for charges not covered by my insurance plan. And if I receive a notice from my insurance company that payment is delayed or denied because additional information is required from me, I agree to promptly contact my insurance company provide that additional information.

If I have insurance, I understand I am responsible to know and understand the terms of my policy with my insurance carrier(s). I understand my insurance carrier(s) will make a final determination of benefits after a claim has been processed and that claims may be subject to limitations and exclusions. And I acknowledge my insurance may not cover medically necessary treatment provided by Gnome Physical Therapy.

If I have a copayment, I agree to pay the full copayment at the beginning of each of my appointments.

If I have a coinsurance, I agree to pay the estimated coinsurance at the beginning of each of my appointments. In the event of overpayment due to estimation, I understand I will be reimbursed the amount overpaid.

I agree to pay a $25 fee for any Cancellation or No Show if I do not provide notice at least 24 hours prior to my scheduled appointment time.

Signature: _____ **Date:** _____

PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE
Relation to Patient: ☐ Parent ☐ Legal Guardian/Representative

CURRENT CONDITION(S)

Which body part(s) are we treating today? ☐ Right ☐ Left

_____

How and when did your condition/injury/surgery begin or occur?

_____

Is your condition/injury a result of a fall?

☐ Yes ☐ No **If Yes, Date of Fall:** _____

Have you fallen two or more times in the past year?

☐ Yes ☐ No **If Yes, Date of Falls:** _____

Is your condition/injury: ☐ Worsening ☐ Stable ☐ Improving

Have you ever had a similar condition/injury in the past?

_____

Please describe your symptoms (mark all that apply):

☐ Sharp ☐ Tingling ☐ Aching ☐ Numbness ☐ Pulling ☐ Burning ☐ Unstable

☐ Heavy ☐ Tight ☐ Shooting ☐ Throbbing ☐ Stabbing ☐ Dull

What increases or aggravates your symptoms?

_____

What decreases or alleviates your symptoms?

_____

After increasing, how long does it take for your symptoms to subside?

_____

On a scale of 1 to 10, please rate the severity of your pain at its <u>worst:</u>

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Imaginable

On a scale of 1 to 10, please rate the severity of your pain at its <u>best</u>:

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Imaginable

Do you currently have any restrictions from your doctor?

_____

_____

Do you currently have any limitations due to your condition(s), at home, work, and/or in leisure activities?

_____

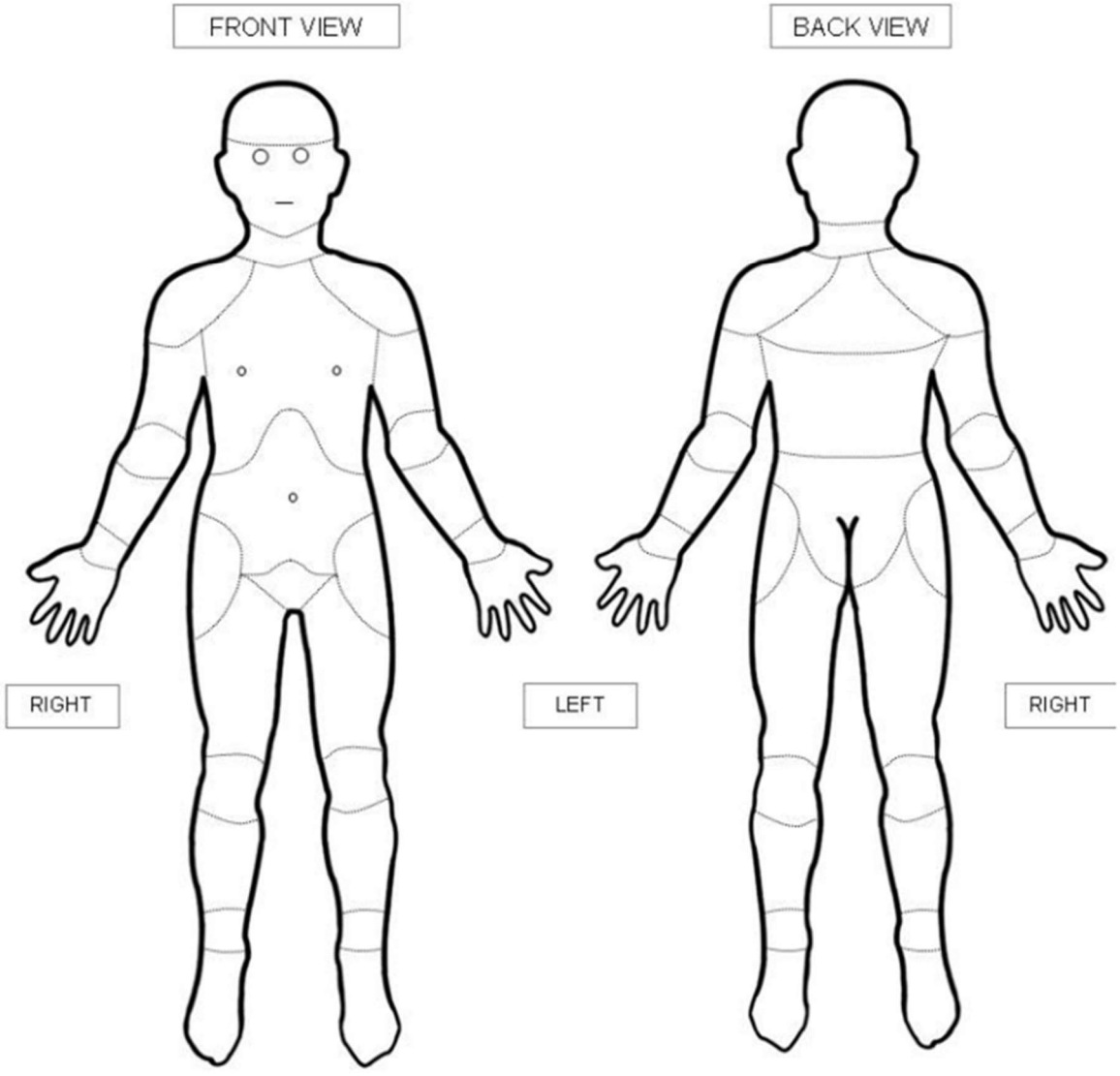
_____

Please list <u>at least 3 important activities</u> which you are unable to perform or have difficulty performing due to your current injury or problem and rate your ability to perform the activities on the 0-10 scales below:

0 indicates you are unable to perform the activity.
10 indicates you have no difficulty performing the activity.

1. _____ 0 1 2 3 4 5 6 7 8 9 10
2. _____ 0 1 2 3 4 5 6 7 8 9 10
3. _____ 0 1 2 3 4 5 6 7 8 9 10
4. _____ 0 1 2 3 4 5 6 7 8 9 10
5. _____ 0 1 2 3 4 5 6 7 8 9 10

On the images below, please mark the location(s) of your symptoms, pain, or injury with "X's":



MEDICAL HISTORY

Please select any condition(s) you currently have, or have had previously:

Yes ☐ No ☐ Allergies

Yes ☐ No ☐ Anemia

Yes ☐ No ☐ Anxiety

Yes ☐ No ☐ Arthritis

Yes ☐ No ☐ Asthma

Yes ☐ No ☐ Cancer

Yes ☐ No ☐ Cardiac Conditions

Yes ☐ No ☐ Cardiac Pacemaker

Yes ☐ No ☐ Chemical Dependency

Yes ☐ No ☐ Currently Pregnant

Yes ☐ No ☐ Depression

Yes ☐ No ☐ Diabetes Type I ☐ Type II ☐

Yes ☐ No ☐ Dizzy Spells

Yes ☐ No ☐ Emphysema Bronchitis

Yes ☐ No ☐ Fractures

Yes ☐ No ☐ Gallbladder Condition

Yes ☐ No ☐ Hepatitis

Yes ☐ No ☐ High Blood Pressure

Yes ☐ No ☐ Incontinence

Yes ☐ No ☐ Kidney Condition

Yes ☐ No ☐ Metal Implants

Yes ☐ No ☐ Osteoporosis

Yes ☐ No ☐ Parkinson's Disease

Yes ☐ No ☐ Poor Circulation

Yes ☐ No ☐ Rheumatoid Arthritis

Yes ☐ No ☐ Seizures

Yes ☐ No ☐ Speech Condition

Yes ☐ No ☐ Strokes

Yes ☐ No ☐ Thyroid Disease: Hypo ☐ Hyper ☐

Yes ☐ No ☐ Tuberculosis

Yes ☐ No ☐ Visual Condition

Please describe any condition marked above as well as any condition you have which is not listed above:

_____

_____

_____

_____

_____

_____

_____

SURGICAL HISTORY

(May also provide a printed list)

Body Region: _____ Procedure: _____ Date: _____

Body Region: _____ Procedure: _____ Date: _____

Body Region: _____ Procedure: _____ Date: _____

Body Region: _____ Procedure: _____ Date: _____

Body Region: _____ Procedure: _____ Date: _____

PRESCRIPTION MEDICATIONS

(May also provide a printed list)

Name: _____ Dosage: _____ Reason for Taking: _____

Name: _____ Dosage: _____ Reason for Taking: _____

Name: _____ Dosage: _____ Reason for Taking: _____

Name: _____ Dosage: _____ Reason for Taking: _____

Name: _____ Dosage: _____ Reason for Taking: _____

Name: _____ Dosage: _____ Reason for Taking: _____

OVER-THE-COUNTER MEDICATIONS

(May also provide a printed list)

Name: _____ Dosage: _____ Reason for Taking: _____

Name: _____ Dosage: _____ Reason for Taking: _____

Name: _____ Dosage: _____ Reason for Taking: _____

Name: _____ Dosage: _____ Reason for Taking: _____

Name: _____ Dosage: _____ Reason for Taking: _____

Name: _____ Dosage: _____ Reason for Taking: _____

VITAMINS AND SUPPLEMENTS

(May also provide a printed list)

Name: _____ Dosage: _____ Reason for Taking: _____

Name: _____ Dosage: _____ Reason for Taking: _____

Name: _____ Dosage: _____ Reason for Taking: _____

Name: _____ Dosage: _____ Reason for Taking: _____

Name: _____ Dosage: _____ Reason for Taking: _____

Name: _____ Dosage: _____ Reason for Taking: _____